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State/Territory Name: **NEW YORK**

State Plan Amendment (SPA) #: **08-65**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

NOV 19 2009

Deborah Bachrach
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

RE: TN 08-65

Dear Ms. Bachrach:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 08-65. Effective October 1, 2008, it denies payment for three specific adverse hospital events, and, beginning November 1, 2009 requires claims seeking any reimbursement involving ten other specific adverse events to be subjected to a medical records review to determine the allowable portion. We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2) 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. I am pleased to inform you that New York 08-65 is approved effective October 1, 2008 and have enclosed the HCFA-179 and the approved plan page.

If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **08-65**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2008**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a)(30) of the Social Security Act** **42 CFR Part 447 Subpart C**	7. FEDERAL BUDGET IMPACT: a. FFY **10/01/08 - 09/30/09** **($411,460)** b. FFY **10/01/09 - 09/30/10** **($411,460)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, Pages 149, 149(a), 149(a)(1), 149(a)(2), 149(a)(i) and 149(a)(ii)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, Pages 149, 149(a) & 149(a)(1)**

10. SUBJECT OF AMENDMENT:
Hospital Inpatient Never Events
FMAP rate - 58.78% based on effective date of 10/1/08

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Deborah Bachrach**	
14. TITLE: **Deputy Commissioner** **Department of Health**	
15. DATE SUBMITTED: **December 8, 2008**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 11-19-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 1 - 2008	20. [illegible]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMSO

23. REMARKS:

[86-1.60] **Billing provisions and limitations on changes in case mix.**

(a) Billing provisions.

For purposes of initial billing of governmental payors only, hospitals may bill upon admission of the patient, subject to the provisions of this Section, provided, however, that the hospital submits a final bill for the patient whose DRG assignment and final payment will be determined in accordance with the provisions of this Subpart. All initial payments made based upon admission of the patient will be reconciled on discharge. Furthermore, adjustments shall be made on a quarterly basis, including any adjustments to rates of payment made pursuant to the provisions of subdivision (b) of this Section.

(1) For purposes of billing upon admission for the first quarter of 1988, an initial admission payment shall be determined as specified in paragraphs (a)(1), (2), and (4) of [section 86-1.52 of this Subpart] the Payment Components Section, except that the operating cost component specified in [section 86-1.52] paragraph (a)(1) shall be determined based upon a hospital specific case mix index (CMI) developed for governmental payors using the data used to calculate initial 1988 rates of payment.

(2) For purposes of billing upon admission for each quarter subsequent to the first quarter of 1988, an adjustment to the hospital's CMI shall be made based upon the allowable aggregate statewide increase in the hospital's CMI, as determined pursuant to subdivision (b) of this Section, for the previous quarter.

(3) Billing and payment provisions for serious adverse events.

Effective October 1, 2008, the New York State Medicaid program shall deny reimbursement or reduce payment for the higher AP-DRG arising from the following three serious adverse events, defined as: avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. These three events are: foreign object left in patient after surgery; air embolism; and blood incompatibility. On and after November 1, 2009, hospitals will be required to bill all claims associated with one of the remaining 10 adverse events using the following procedures:

1. For those cases where a serious adverse event occurs and the hospital elects to receive no payment for the admission (i.e., it is expected that Medicaid will deny the entire payment based on the type of event), the hospital will notify Medicaid of this case by submitting a claim using a new rate code 2590 (non-reimbursable with serious adverse events), along with the requisite billing information submitted with a claim.

   Department of Health will identify claims billed with rate code 2590 and instruct the Island Peer Review Organization (IPRO), the New York State Medicaid review agent, to request the medical record for the admission and conduct a case review.

2. For those cases where a serious adverse event occurs and the hospital anticipates at least partial payment for the admission, the hospital will follow a two-step process for billing the admission:

   (i) The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.

(ii) Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:

- 2591 (DRG with serious adverse events), or
- 2592 (Per Diem with serious adverse events)

The adjusted claim will then pend to the Department and will be forwarded to Island Peer Review Organization (IPRO) for further review. IPRO will review the medical record for the case to determine appropriate payment. Once IPRO has completed its review of the medical record, a preliminary notification indicating their findings will be issued. Hospitals will be required to respond to this preliminary finding within thirty days indicating whether it agrees or disagrees with the finding. If the provider disagrees with this preliminary finding, they may appeal by submitting additional rationale and supporting documentation to the IPRO. IPRO will then re-review the case taking into account the provider's rationale and supporting documentation. A final determination will be made at the conclusion of this process.

The thirteen "never events" are as follows:

(1) Surgery performed on the wrong body part
(2) Surgery performed on the wrong patient
(3) Wrong surgical procedure on a patient
(4) Foreign object inadvertently left in patient after surgery
(5) Medication error
(6) Air embolism
(7) Blood incompatibility
(8) Patient disability from electric shock

(9) Patient disability from use of contaminated drugs

(10) Patient disability from wrong function of a device

(11) Incidents whereby a line designated for oxygen intended for patient is wrong item or contaminated

(12) Patient disability from burns

(13) Patient disability from use of restraints or bedrails

Hospitals receiving payment under New York State Medicaid shall be required to provide information, through Present on Admission (POA) indicators, on each admission. These POA indicators shall designate which procedures or complications were present on admission, and which occurred during or as a result of hospital care.

This provision applies to all Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

(b) Limitations on changes in case mix.

(1) For the rate period commencing January 1, 1994 and ending June 30, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in [an] a historical rate year shall not exceed, on a cumulative basis, two percent from the 1992 non-Medicare statewide average reported case mix for 1994, excluding case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes.

For the rate period July 1, 1994 through December 31, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in [an] a historical rate year shall not exceed, on a cumulative basis when taking into consideration the rate of growth between the 1992 and 1987 rate years, six and two tenths percent from the adjusted 1992 non-Medicare statewide average reported case mix for 1994. For the rate period January 1, 1995 through March 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare [S]statewide average case mix. For the rate period April 1, 1995 through December 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, two percent from the 1992 non-Medicare statewide average reported case mix. For the rate period January 1, 1996 through December 31, 1996, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare statewide average reported case mix.

The maximum allowable increase shall be applied to adjust rates of payment for the periods commencing January 1, 1990 and ending December 31, 1996, using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase

in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter except for the period July 1, 1994 through December 31, 1995, as noted above; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basis malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to [section 86-1.63] non-Medicare trimpoints of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year case mix index determined pursuant to paragraph (4) of [subdivision (b) of section 86-1.75] Estimate of Real Non-Medicare Cumulative Case Mix Increase by the statewide base year case mix index determined pursuant to paragraph (2)[of subdivision (b) of section 86-1.75] and subtracting one from the result.